ILLINOIS DEPARTMENT OF PUBLIC HEALTH
NURSING EDUCATION SCHOLARSHIP PROGRAM
Academic Year 2016-2017

The application submission period is May 1 through May 31. If you mail an application to the Department, it must be **received** by May 31. Applications received after May 31 **will not** be accepted. Applications postmarked by May 31 but received by the Department after May 31 **will not** be accepted.

After the Department receives your application, you will receive a confirmation e-mail. Follow the directions listed in the e-mail to complete your application.

Ensure that the e-mail address you provide in the application is correct and valid. Communication between the Department and the applicant will be through e-mail. The Department **is not** responsible if an applicant provides an inaccurate or invalid e-mail address.

If you are a current recipient of the scholarship, **DO NOT** submit another application. Contact program staff at 1-800-821-3635 or dph.nesp@illinois.gov and request a scholarship renewal.

By submitting this application, you are stating that you have read Sections 6 and 6.5(e) of the Nursing Education Scholarship Law: http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1167&ChapterID=18. You also agree that your application is not complete until the Department receives the following:

1. a copy of your enrollment or acceptance letter to an approved institution's nursing program,
2. a copy of your Illinois driver's license or State-issued identification card documenting that you have been an Illinois resident for at least one year prior to applying for the scholarship,
3. a copy of your **notarized** birth certificate, or documentation that you are a naturalized citizen, or documentation that you are a lawful permanent resident of the U.S.,
4. your latest official transcripts which indicate your Grade Point Average. Printouts of online grade records **will not** be accepted,
5. your current Student Aid Report (SAR) from your FAFSA,
6. a copy of your current Illinois nursing license (if applicable), and
7. your signed Confirmation and Release form (the form is attached to the confirmation e-mail you will receive from the Department).

Contact program staff if you do not receive a confirmation e-mail or if you need to make changes to your application.

Contact information: 1-800-821-3635 or dph.nesp@illinois.gov

APPLICATION

Name _____
(first) (middle) (last)

Mailing address _____

_____
(city) (state) (zip)

Illinois Legislative House District _____
Illinois Legislative Senate District _____
U.S. Congressional District _____
(Choose the districts based on your mailing address. If you need assistance, go to http://www.elections.il.gov/DistrictLocator/DistrictOfficialSearchByAddress.aspx)

Date of Birth _____ County of Residence _____

Telephone _____ Cell Phone _____

Driver's license or State-issued ID number _____

E-mail Address (required) _____

Gender Female _____ Male _____

Citizenship

Are you a citizen of the United States? Yes _____ No _____
In no, are you a lawful permanent resident alien? Yes _____ No _____

Years lived in Illinois? _____

Ethnicity (Optional - information is used in the program's annual report to the Illinois General Assembly)

American Indian / Alaskan Native _____ Hispanic _____
Asian / Pacific Islander _____ White, non-Hispanic _____
Black, non-Hispanic _____ Other _____

In which nursing program will you be enrolled during academic year 2016-2017?

_____ Practical nursing program
_____ Hospital-based diploma program
_____ Master degree (choose one)
Nurse educator _____
Advanced practice nurse _____

_____ Associate degree program
_____ Baccalaureate degree program
_____ Doctorate degree (choose one)
PhD _____
Doctor of Nursing _____
Doctor of Nursing Science _____
Doctor of Nursing Practice _____
Doctor of Nurse Anesthesia Practice _____

Name and city of nursing school where you will be enrolled

_____

_____

(Per the Nursing Education Scholarship Law, scholarships can only be awarded to recipients who attend an approved institution. To view a list of approved nursing schools, go to this site: http://www.idfpr.com/Forms/DPR/NurseSchools.pdf

Number of credit hours required to graduate _____

Which year will you be starting in school (indicate a number between 1 and 5) _____
LPN = 1, Associate degree = 1 or 2, Hospital-based diploma = 1, 2, or 3, Baccalaureate degree = 1, 2, 3, or 4, MSN degree for nurse educator = 1, 2, or 3, MSN degree for Advanced Practice Nurse of Doctoral degree = 1, 2, 3, 4, or 5.

During academic year 2016 – 2017, will you be enrolled:

Full-time (12 credit hours or more) _____
Part-time (4-11 credit hours) _____
Combination (full-time and part-time) _____

Do you have prior nursing education? Yes _____ No _____

If yes, what type:

Certificate in practical nursing _____ Associate degree in nursing _____
Hospital-based diploma in nursing _____ Baccalaureate degree in nursing _____

Do you have a current Illinois nursing license? Yes _____ No _____

If yes:

Advanced practice nurse license number _____
Registered professional nurse license number _____
Practical nurse license number _____

Are you receiving other types of financial aid that have service commitments that prevent you from fulfilling the service commitment from this scholarship program? Yes _____ No _____

Grade Point Average (GPA) _____
If you don't know your GPA, leave this blank. As soon as your transcripts are received, your GPA will be updated. Due to the applicant selection criteria at 77 Illinois Administrative Code 597.220(b)(2)(C)(i), applicants whose GPA is less than 3.00 may not be considered for a scholarship.

Expected Family Contribution (EFC) _____
If you don't know your EFC, leave this blank. As soon as your SAR is received, your EFC will be updated.

SOCIAL SECURITY STATEMENT

The Illinois Department of Public Health requests your Social Security number (SSN). You are not required to disclose your SSN at this time, and no rights, benefits, or privileges will be denied if you choose not to disclose your number. However, your SSN will be required at a later date if you are selected to receive funds through the Nursing Education Scholarship Program. If you agree to disclose your SSN, it will be used for collecting information from your nursing school.

If you disclose your SSN, please indicate your number below and sign this section.

___ ___ ___ - ___ ___ - ___ ___ ___ ___

_____ _____

Applicant's signature Date

Applications must be received on or before May 31, 2016

Mail application to:

Illinois Department of Public Health
Center for Rural Health
Nursing Education Scholarship Program
535 West Jefferson Street, Ground Floor
Springfield, Illinois 62761-0001

It is recommended that you send your materials via certified mail or use UPS or FedEx so that you can track your submission.